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Fees for outpatient operations in Germany: development, evaluation and European comparison

Wolfgang Rulf [a,*], Richard Cowlard [b], Dirk De Jong [c], Claude De Lathouwer [d], Viktor Grablowitz [e], Andreas Halder [f], Juan Marin [g], Marc-Claude Marti [h], Jean-Patrick Sales [i]

[a] *Bergstrasse 9, D-40699; Erkrath, Germany*
[b] *The Old Cottage Hospital, Alexandra Road, Epsom KT17 4B1, UK*
[c] *Academisch Ziekenhuis Vrije Universiteit, PO Box 7057, NL-1007 MB Amsterdam, The Netherlands*
[d] *Avenue du Duc Jean 71–73, B-1083; Bruxelles, France*
[e] *Seilerstätte 7/3/7, A-1010 Wien, Germany*
[f] *Asklepios-Klinik Birkenwerder, Hubertusstr. 12, D-16547 Birkenwerder, Germany*
[g] *Avda. Ramon de Carranza, Edif. Presidente, Portal B-2, 4°BE-41011 Sevilla, Italy*
[h] *Hopital Cantonal, Rue Micheli-du-Crest 24, CH-1211 Geneve 14, Italy*
[i] *Centre Administratif Andre Benech, 191, Av. du Doyen Gaston Giraud, F-34295 Montpellier Cedex 5, France*

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Abstract

In Germany, discussions on the fees for statutory sickness insurance for ambulatory surgery has, in the last few years, become almost a symbol of dispute for the German health services. Outpatient surgeons complain about the fact that the fees do not cover their services. They see innovation severely threatened by bureaucracy, profitability by planned economy, rights by reasons of State, aggravated by the 'reform' attempts of the Greens and Socialist coalition Federal Government. On the other hand their opponents complain about the money mindedness of the doctors. Intentional panic or real disaster? The fundamental consideration to clarify this question is based on a comparison of the German statutory medical insurance fees and private fees with our neighbours. In Europe an economic area with similar prices for goods, services and wages, even 'outpatient operations' services with comparable cost rates should be paid for at a corresponding level. Any discrepancies would give cause to look for an explanation by analysing the historic development of fees and the question of a fair comparison between operations and the non-operative services. © 2000 Elsevier Science B.V. All rights reserved.

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1. European comparison

The medical insurance and private fees for three key operations, (non-laparoscopic inguinal hernia repair, orchidopexy [cryptorchidism] and male sterilisation operations) in England, the Netherlands, Belgium, France, Spain, Italy, Austria and Switzerland were compared with each other by way of example.

The majority of the European operation fees was given by the current presidents of the national associations for ambulatory surgery. Occasionally Internet contacts helped and once the author had to pretend to be a potential patient.

On the whole the fees could only be roughly compared because of the different health systems and fees that vary according not only to countries but also to regions (e.g. Switzerland and England). The operation costs are, where given, divided into doctor's fees and material expenses. Anaesthetic costs have not been considered. Unlike Germany, where ambulatory surgery is carried out in free standing units, outpatient operations in neighbouring countries are carried out almost exclusively by (private practice) doctors at hospitals.

* Corresponding author.

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Table 1
European outpatient operation fees in Euro

Country	Orchidopexy unilateral			Inguinal hernia repair unilateral			Vasectomy		
	Doctor's fee	Expense	Total	Doctor's fee	Expense	total	Doctor's fee	Expense	Total
D	?	?	180	?	?	255	?	?	55
GB	?	?	590	?	?	640	?	?	320
NL	97	534	631	82	534	616	53	122	175
B	164	300[a]	460[a]	260	300[a]	560[a]	85	160[a]	245[a]
SP[b]	?	?	843	?	?	843	?	?	216
F[c]	125	300[a]	425[a]	110	300[a]	410[a]	45	160[a]	205[a]
CH	?	?	525	?	?	540		not paid by social security	
I						931			
A	Not available as outpatient service unless privately paid total case lump sum for inpatient surgery (3 days) ca. 148 000						Does not exist as independent operation unless privately paid		

[a] As these costs were not reported or could not be specified in one amount, the estimated costs for operation room, post-operative nurse fee and material expenses have been taken according to the German KBV management calculation (see text).
[b] Total case lump sum for outpatient/inpatient surgery including anaesthetic costs.
[c] Privately operated hospitals.

Because of this a subtle comparison of the fees system is not possible, but the question of scale and thus finally the question of the reasonableness of the requests of German surgeons can be answered at any time.

The results are shattering from a German point of view: Although the medical insurance fees in neighbouring countries vary widely, the German rates are far below on the table (see Table 1).

The same applies to private fees which are sometimes even lower than the social medical insurance fees of neighbouring countries (see Table 2).

2. Conclusion

With fees which only amount to a quarter or at the most half of those of their European colleagues with rather higher costs and wages, this is an impressive description of the disastrous situation of German doctors. Add to this the fact that abroad surgeons usually operate in hospitals. Public medical insurance pays them a fee and costs are settled directly with the hospitals. The business risk of foreign colleagues must thus be ignored when comparing with the Germans in their own businesses.

3. Explanation — development and evaluation of the German fees for outpatient surgery

The reasons for these striking differences are to be found in the German statutory health system, to be precise

1. In the principle of the 'total reimbursement with releasing effect'.
2. In the assessment of a doctor's services according to 'political' interests and not according to a business management value assessment.

3.1. To 1: total reimbursement with releasing effect

The statutory medical insurance pays the regional association of medical insurance doctors in advance a specified lump sum for outpatient services according to the type of insurance and number of members (total reimbursement), which releases it from any further payment obligations for a given period. Periodic amendments are not done according to medical needs (e.g. shifting services from in-patient to outpatient), but according to strict political guidelines, the maxims of which are contribution stability. The doctors' fees in the statutory medical insurance are not expressed in DM but in points (in contrast to private insurances). The

Table 2
European/US private outpatient operation fees in Euro

Country	Inguinal hernia	Vasectomy
	Total fee	Total fee
D	370	250
GB	1.280	490
NL	770	?
SP	350	240
CH[a]	1.380	310
A	1.500	480
USA[b]	5.520	1.430

[a] Only doctor's fee.
[b] Total case lump sum Mayo clinic USA.

total reimbursement is divided by the sum of all the points charged by the doctors in the medical insurance association and thus a points' value is calculated. Inevitably the point value falls if the amount of services increases because the total reimbursement, as we have said, is not adapted to medical need.

Between 1992 and 1999 the points value dropped by about 30%.

Furthermore, the German health service is characterised by its bureaucratic, planned economic basic structure, by the strong division into an outpatient and inpatient supply sector with different reimbursement, financing and administration structures. Impermeable finance sectors prevent 'the money following the service' when services are transferred from in-patient to out-patient.

However, this cannot be the only reason. The second point has a more serious effect:

3.2. To 2: assessment of fees

Schedules of fees are basically, like all price lists, relative assessments. Common to all is the fact that, if the basic value has been calculated in a correct business-like way, and if all other services have also been assessed to see if they are in a fair ratio, whether in points or euros, then this must also lead to a positive result from a business management point of view — assuming sufficient demand. A good example is the fee reform attempted in 1997 by the Federal Association of statutory medical insurance physicians (KBV) for outpatient operations: the fee for a given operation is calculated from the product of the operation stopping time and a calculated basic value (the min rate).

> This reform failed because of opposition from the social health insurance companies because, in spite of the most stringent calculation criteria, it would have led to considerably higher fees and other relative assessments for operations. But the in-patient case costs currently in force are still way above the outpatient fee requests that were denied. Because of the impermeable finance sectors this advantage cannot be realised immediately. Furthermore, fear of the statutory health insurance companies is enough to have to give up important bureaucratic principles (total reimbursement with releasing effect), to pay the higher inpatient costs that have already been calculated according to their planned management.

The current points evaluation system in force for outpatient operations is not based on any rational business calculation. Neither doctors in private practice (because of the risk of decreasing point value), nor the hospital doctors (because of the risk of a beds' surplus) were or are interested in shifting services from inpatients to outpatients. Therefore outpatient operations were clearly allotted a 'political' number of points, which bore no relationship to their real value, in order to avoid incentives. But most surgeons are still not aware of this procedure.

> With few exceptions, regional promotions of outpatient operations served and serve, because of their size, as a front; the political promotion (1993) was in typically planned management fashion, catastrophically counter-productive.

Examination of the relative assessment of conservative and operative outpatient services is used to embody the points undervaluation of outpatient operations.

4. Methodology

As we have already said, in the actual schedule of fees of statutory medical insurance physicians (EBM), there is no basic value calculated by management which is comparable with the minute value of the KBV reform of 1997. Therefore, an alternative value must be found in the EBM which fulfils the criteria of an 'alternative unit value', correct absolute evaluation, basic medical services and basic cost rate. Paragraph 60 of the EBM (basic physical examination) practically fulfils these criteria. It is a basic service done by all doctors, requires the minimum conceivable cost rate and is assessed satisfactorily at 320 points (at about 0.035 Euros/point, 11.20 ?). All services whose points measurement is in a fair (correct) relative assessment to paragraph 60 will obtain-theoretically-the same-modest gain.

If you compare the points of a given operation with the 320 points in paragraph 60, you will get a relative value ratio, which can only be assessed intuitively for itself alone as fair or not. The fees of the KBV reform attempts mentioned at the beginning (in German marks (DM) not in points!) were referred to in order to quantify the fair relative assessment. These DM-fees produced a comparison in relation to the DM-value of paragraph 60 and using this the fair relative assessments of the valid EBM operation fees, expressed in percentages, were calculated.

If a given operation is assessed relative to paragraph 60, it would have a relative assessment of 100% in Table 3. Because of the still just positive basic calculation values, each operation with a fair assessment level of less than 100% is not a cost covering performance. (see Table 3).

Table 3
Relative value of some outpatient surgery fees in relation to the fee of the basic physical examination (BPE)

Basic physical examination/operation	Relative assessment EBM[a]	Relative assessment KBV 97[b]	% Fair assesment
BPE/hydrocele/spermatocele	1:6	1:20	30%
BPE/implantation DJ-splint	1:0.9	1:23	4%
BPE/extrauterine gravidity	1:17	1:40	42%
BPE/tonsillectomy	1:3	1:18	17%
BPE/cellulitis	1:6	1:22	28%
BPE/phimosis	1:4	1:19	21%
BPE/vasectomy	1:4.4	1:16	27%
BPE/inguinal hernia repair	1:19	1:33	59%
BPE/orchidopexy	1:13	1:36	36%

[a] EBM, actual fee order for statutory health insurance.
[b] Management calculated fees (KBV data).

Table 4
Relative value of examplary operations compared with each other

Op/Op	EBM[a]	KBV 97[b]	RBRVS[c]
Orchidopexy/inguinal hernia repair	0.65	1.1	1.0–1.22
Resectioning arthroscopy (30 min)/transurethral resection of a large bladder tumour	4.2	1.0	1.28

[a] EBM, actual fee order for statutory health insurances.
[b] Management calculated fees (KBV data).
[c] American resource based relative value scale.

Please note that this evaluation scheme does not claim to be a business management model, but is a logical starting point to embody the lack of assessment for outpatient operations in the EBM.

An evaluation 'off the top of one's head', also inevitably leads to an irrational relative assessment of operations compared with each other (Table 4). Objective reference points are on the one hand once again the KBV data and on the other hand the American resource based relative value scale, (RBRVS). (see Table 4).

5. Results

All operations examined in the spot check were seriously and completely irrationally undervalued (see Table 3). The 30% fair assessment of the hydrocele operation for example means that this operation would be correctly assessed at about 6000 points instead of the current 2000 points, tonsillectomies with 5900 points instead of 1000 points. The percentage of fair relative assessments in the sample ranges from 5% (putting on a DJ splint) up to a maximum of 60% (inguinal hernia).

This chaotic value measurement also continues when evaluating operations amongst themselves (see Table 4). And so urologists must be satisfied with a 75% lower fee for a resection of a large bladder tumour than their colleagues who do arthroscopy for the same expense (resectioning arthroscopy, operation time 30 min).

6. Analysis

Working on the premises that foreign colleagues cover their costs in operations, it was to be expected that operations that have a fair assessment of less than 100% in Germany, must inevitably be assessed higher abroad (or the logical approach was not correct). Surprisingly the level of undervaluation (percentage of fair assessments) is reflected in the fees' discrepancy again. (And so with a 25% fair assessment, our neighbours are paid on average four times more than the German fee).

It is also surprising that, for example, in the Netherlands, the costs settled for doctors fees that are paid from the public purse, are higher than the total private fee in Germany!

German private fees are generally lower than the level of fees for European public health systems.

And it is only logical that in a comparison of private fees, the Germans (and the Spanish) are a long way down at the bottom of the league. (Table 2).

The miserable state of fees complained about by the German outpatient surgeons is indicated by the information above. Its cause is the striking, politically intentional, relative undervaluation of outpatient operations. The drop in points' value is just the 'final straw'.

The fees of our neighbours are based on an acceptable framework around a middle value which represents a certain rationality of evaluation in spite of differing social systems. Although with private fees the range of variation is considerable.

In Germany, however, a fundamental reform is necessary, not only, but especially for operation fees, both with regard to the evaluation of the service and the description of the service.

A look at the new law coming into force on 1.1.2000 gives little encouragement. The red–green Federal coalition government is going full steam ahead into the past: bureaucracy and control instead of flexibility and competition, strict finance sectors instead of a free flow of money to where the work is done most economically. Outpatient operations in Germany…could possibly become a thing of the past.